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ORIGINAL DEPARTMENT.

COMMUNICATIONS.

MULTILOCLAR OVARIAN CYST—REMOVAL.

BY D. J. MERRIMAN, M.D.,
Of Wilmington, Ill.

Mrs. L., aged thirty-two years, married eight years, mother of two children, eldest six and youngest four years of age. Noticed soon after last confinement a small tumor in the left side, which increased slowly in size for some time and then disappeared, followed by an attack of peritonitis. After some months another tumor made its appearance in the same region, and at the time I was called to see the case, April 25th, 1875, it had attained the size of a fetal head at term. I would say, in this connection, that this case has been continually under my care and observation from that date to this. After a thorough examination, I diagnosed an ovarian tumor; it was freely movable, and slight fluctuation could be felt. I gave her tonics, and occasionally opiates, as the case required. It gradually increased in size until she, at my suggestion, visited Dr. A. W. Heise, of Joliet, Ill., on May 26th, 1876, who concurred with me in my diagnosis, and advised her to let it alone as long as it gave her no great inconvenience. She was able at this time to do her own work.

Some time in January, 1877, she called my attention to a tumor on the right side of her neck. It started from behind the clavicle and extended upward behind the sterno-cleido-mastoid muscle, lying upon the sheath of the common carotid. It was about three inches in

length, and two in breadth, nodulated and very hard; firmly bound down by the fascia of the neck. There being cancer in the family, her grandmother and one aunt having died of that disease, and another still suffering from it, I was fearful it might be a scirrhus tumor. As it grew rapidly in size I injected into it fifteen minims of fluid extract of ergot, which set up a good deal of inflammation and swelling.

One week afterward I injected it again, and on withdrawing the needle I noticed a little pus. A free incision was then made, which was followed by a large amount of suppuration. The tumor gradually disappeared, leaving a small cicatrix. On the 22d of August, the abdominal tumor having become a burden, and interfering greatly with the vital functions, she visited Dr. Heise again, and while in Joliet had a severe attack of cholera morbus, and did not return for several days. Dr. Heise advised paracentesis, which I accordingly performed on the 28th of August, removing twelve and a half pounds of thick, viscid fluid, heavily loaded with albumen. She gained in flesh and strength rapidly, and could get around with comfort. On the 30th of September, the tumor having refilled, I again drew off the fluid (twenty-one pounds), which gave her great relief.

In the meantime, at the husband's request, together with that of her parents, I concluded to remove the tumor, provided Dr. E. R. Willard, of this place, would assist me. About the 20th of October Dr. Willard visited the patient with me, and after examining the case, kindly consented to assist me. October 25th ordered an infusion of salts and senna, which operated

thoroughly. October 26th, 12 m. the patient took one ounce of brandy, and at 1.30, everything being in readiness, the room at or above 80°, the patient was put upon the table, and ether administered by Dr. G. E. Willard, son of Dr. E. R. Willard, who had been invited to be present. As soon as the patient was fully etherized, I commenced the operation by making an incision about four inches in length, through which I introduced my fingers, for the purpose of determining whether any adhesions existed. Not finding any of any account, the incision was extended from the umbilicus to the pubis, then passing my right hand into the peritoneal cavity, sweeping it around the tumor, breaking up all adhesions, I gently lifted the cyst, while my assistant seized it with a pair of strong dressing forceps, drawing it carefully through the opening, sufficiently far to evacuate its contents outside of the peritoneal cavity. As we had not a suitable trocar, this was done with a bistoury, the patient lying partly on her left side, and the fluid conveyed on an oilcloth into a bucket close at hand. As soon as the sac was sufficiently reduced in size, it was turned out of the cavity, the pedicle secured by the application of the clamp, and severed close to the tumor. The cavity was then sponged out with carbolized warm water and the wound closed with silk sutures, taking up only the peritoneum and integument, which was a mistake, as will be seen hereafter. The pedicle was brought out between the second and third sutures from below, and the clamp adjusted crosswise of the incision; a little cotton dipped in carbolized oil was laid over the wound and a thick layer of cotton spread over the whole abdomen, a flannel bandage applied and the patient put to bed. The operation was performed in twenty-five minutes; the tumor and contents weighing thirty pounds.

Thirty minutes after operation her pulse was 86 and temperature 98°; hot bricks were put to her feet, and one-eighth of a grain of morphia given, which was followed by slight nausea, for which small doses of brandy and water were given. 6 p. m. Pulse 88, temperature 99½°. 9 p. m. Pulse 90, temperature 99½°. Drew off half a pint of urine, of normal color and consistence; ordered beef tea and milk, with a little brandy to be given in alternation through the night. 11.30 p. m. Pulse 90, temperature 99½°.

October 27th, 3.30 a. m. Pulse 90, temperature 100°. Drew off urine and gave one-eighth

grain morphia. 8 a. m. Pulse 100, temperature 100°. Continue milk and beef tea; urine drawn every four hours. 12.30 p. m. Pulse 96, temperature 100½°. 6 p. m. Pulse 100, temperature 100½°.

October 28th, 4 a. m. Pulse 100, temperature 99½°. Some pain; ordered one-eighth grain of morphia every four hours. 9 a. m. Pulse 100, temperature 99½°. Some nausea. 12 m. Pulse 106, temperature 99½°. Has vomited some; five grains citrate of iron and quinia was ordered to be given every six hours, in alternation with the morphia. 6 p. m. Pulse 114, temperature 100½°. Dressed wound with carbolized oil; nausea continuing, ten grains of subnitrate of bismuth was given and repeated in two hours.

October 29th, 1 a. m. Pulse 116, temperature 99½°. Has not tolerated the citrate; ordered it discontinued, and gave hypodermic injection of morphia, one-eighth of a grain. 8 a. m. Pulse 110, temperature 99½°. Gave an enema of warm carbolized water (water one pint, acid three or four drops); also ordered a two-grain pill of quinia every four hours, and milk and beef tea to be continued. 1 p. m. Pulse 104, temperature 99½°. Gave another injection of morphia. 6 p. m. Pulse 108, temperature 99½°. Has passed urine during the day in bed-pan. There has been some nausea and hiccup through the day.

October 30th, 8 a. m. Pulse 94, temperature 98½°; has taken a little solid food; gave another enema of carbolized warm water. 6 p. m. Pulse 96; temperature 100°; stomach irritable; ordered milk and lime water, which was retained; gave an injection of one-eighth grain of morphia.

October 31st, 8 a. m. Pulse 92; temperature 99½°; gave an enema of beef-tea, and continued milk and lime water. Patient did not rest well, and feels anxious and uneasy. 1 p. m. Pulse 95; temperature 99°. 6 p. m. Pulse 105; temperature 99½°.

November 1st, 8 a. m. Pulse 95; temperature 99½°. Rested well during the night; ordered beef-tea and milk; no opiate since the 30th. 6 p. m. Pulse 104; temperature 99½°.

November 2d, 8 a. m. Pulse 103; temperature 98½°. Rested well; gave an enema of warm water and an ounce of castor oil, which operated in an hour, and gave her great relief; the bowels have not moved since the operation. 6 p. m. Pulse 108; temperature 99°; has taken solid food during the day.

November 3d, 8 A.M. Pulse 97; temperature 98½°. Rested well, and takes food with relish. 1 P.M. Pulse 100; temperature 99°. Removed sutures. 6 P.M. Pulse 105; temperature 101°.

November 4th, 8 A.M. Pulse 120; temperature 99; 6 P.M. Pulse 125; temperature 101°. Is restless and anxious; takes food sparingly.

November 5th, 8 A.M. Pulse 120; temperature 99°. Did not rest well until toward morning. Removed clamp and one suture that had been overlooked. Pedicle firmly united in the wound, and the incision closed by first intention. 6 P.M. Pulse 120; temperature 99½°. Ordered an enema, which moved the bowels freely, and four grains cinchonidia every four hours.

November 6th, 8 A.M. Pulse 110; temperature 98½°. Rested well during the night; appetite good. 6 P.M. Pulse 104; temperature 99½°. Complained of some smarting after urination; ordered ten grains of bromide potassium every six hours.

November 7th, 8 A.M., pulse 100, temperature 98½°. Bowels moved once, and left some uneasiness: ordered ½ ounce of castor oil, and gave one grain saponaria, which gave her relief. 6 P.M., pulse 105, temperature 98½°.

November 8th, 8 A.M., pulse 110, temperature 99°. Bowels moved once; appetite good; wound healed throughout, except a superficial surface around the end of the pedicle. 6 P.M., pulse 118, temperature 100°.

November 9th, 8 A.M., pulse 125, temperature 99½°. Some pain in bowels; ordered ½ ounce castor oil, which operated about noon. 12 M., pulse 120, temperature 100°. Gave a dose of saponaria, and ordered cinchonidia resumed, as it had been dropped for a day or two. 6 P.M., pulse 124, temperature 99°.

November 10th, 8 A.M., pulse 112, temperature 99°. Rested moderately well. Gave 6 grains cinchonidia this morning, and continued it in 4-grain doses every four hours. 6 P.M., pulse 100, temperature 98½°. Sat up two hours during the day; appetite good.

November 11th, 8 A.M., pulse 102, temperature 99½°. Patient feels well; appetite good and bowels regular.

November 12th, 8 A.M., pulse 110, temperature 98½°. Sits up three or four hours during the day, and is gaining strength rapidly.

November 15th. Still some rawness around the pedicle, and on close examination I found a deep suture, which I removed. Up to this

time she had worn the cotton and bandage, without adhesive straps. At this time there was some bulging along the line of the cicatrix, so I applied some straps across the abdomen, and advised her to wear the cotton and bandage as before.

November 20th. Examined the case and found some rawness along the line of the incision, produced by rolling in the integument as I applied the adhesive straps. I also found that the end of the pedicle had separated from the surrounding tissues nearly down to the peritoneum.

I dressed it with balsam fir every day until it all healed, except around the pedicle, which was only partially healed on January 20th, 1878. At this time I touched it with carbolic acid, which did no good. January 24th, I cut out the end of the pedicle, and dressed the wound with balsam fir, and directed her to keep quiet, but instead of doing so she went visiting. There was quite an amount of inflammation set up, and she was confined to her bed for a number of days. The wound healed up nicely, and at this date she is about the house. There is a point to which I wish to call attention, viz., the method of closing the incision at the time of the operation. I think now, that had hare-lip pins been used, set deep into the tissues, a firmer cicatrix would have been obtained. As it is, she will be obliged to wear an abdominal bandage or supporter as long as she lives, which will not be much of an inconvenience compared with what she has endured.

I am under obligations to Dr. Willard for his assistance and interest in the case, as can well be seen from a partial report of it in the *Chicago Medical Journal and Examiner*, of January, 1878.

RUDIMENTARY STRUCTURES IN THE HUMAN RECTUM. SPIRAL FOLDS AND VALVULAR PROJECTIONS OF ITS MUCOUS MEMBRANE.

BY REUBEN A. VANCE, M. D.,
Of Gallipolis, Ohio.

I desire to call attention to a structure in the terminal portion of the large intestine, *intestinum rectum*, which properly seems to fall in the class of rudiments. I allude to those duplications of the intestinal walls known as the valves of Houston. In 1865, while dissecting in the University of Michigan, I found that in my sub-

ject the mucous membrane lining the rectum was thrown into a spiral arrangement, which, commencing on the right side of that organ, at its junction with the sigmoid flexure of the colon, passed downward, backward, and to the left, until the side of the canal opposite the point where the valve commenced was reached. In this situation the duplication was as large as on the right side above, where it commenced. The same was true of a point corresponding with the base of the bladder on the internal aspect of the anterior wall of the viscus. The valve could be traced from this situation, at first downward and backward to the posterior wall of the rectum, and then downward and forward to a point about three-quarters of an inch above the anal orifice, where it seemed to terminate on the left side in one of the columns of Morgagni. The valve gradually enlarged and became more and more prominent as its course from the left side along the posterior wall and around the right side was traced from the column of Morgagni to the base of the bladder. In the latter situation it was more than half an inch broad, and this breadth was preserved along the anterior wall and up the side of the rectum, until it joined the duplication on the left side, with the exception of one point, where, for about an inch and a quarter, the duplication was very narrow indeed, perhaps not exceeding the eighth of an inch in depth. This defective spot in the spiral arrangement of the fold of lining membrane seemed to be situated on the left side, and was immediately in front of the broad and well-marked valve, placed below and on the side opposite to the point where the duplication was first manifested, at the junction of rectum and colon. The duplication of the mucous membrane could be traced from this defective point spirally around the left side and posterior wall of the rectum, to end on the right side at the termination of the colon, where it blended with the lining membrane of the part; between the valves a narrow portion, similar to that between the valve on the left side, and the one opposite the base of the bladder, could be seen on the posterior wall of the intestine. In other words, from one of the columns of Morgagni, on the left side of the terminal portion of the rectum, to a point on the right side of the junction of the colon and rectum, there was a duplication of the lining membrane of the latter organ—a duplication

varying in width but always persisting—which pursued a spiral course, and made one and a half circuits of the intestine. The free edge of this spiral duplication of the lining membrane of the rectum was directed inward; the thickness as well as the width of the valves varied in different situations. The structure was thickest and firmest where the fold was widest; this was especially so at its commencement, superiorly, on the right side, opposite the base of the bladder on the anterior wall, and at a point midway between the two, on the left side; while between these points of greatest development (particularly on each side of the one located on the left wall of the rectum) were the situations where the duplications were least marked. It is to be regretted that this specimen was removed from the body, and its relations with neighboring parts broken up, before the peculiar character of its lining membrane was observed.

During the past twelve years I have made critical examinations of the rectum in thirty-four cases. In other instances I have either seen the rectum after it has been removed, or have examined it on the cadaver without taking it out. But in the thirty-four cases alluded to I have examined it, so far as possible, in its natural situation, and then taken it out and subjected it to a thorough investigation. In five cases the appearances have resembled those just described, and in seven there were separate projections meriting the name of valves. In all thirteen cases—for the case detailed at length is included—there were duplications of the mucous membrane on the anterior wall, opposite the base of the bladder, and at the junction of the colon and rectum on the right side of the intestine, while in twelve of the cases the valve on the left wall, above the base of the bladder, was also distinctly marked. In three of the seven cases in which the valves were separate, there was a valve about an inch above the anus on the left side; and in each of these cases the valves at the base of the bladder, the left wall of the rectum, and on the right side at the junction of colon and rectum, were well developed. In one of the remaining four cases of this group there were but two valves; one at the base of the bladder, and the other at the commencement of the rectum on the right side; while in the other three, the separate projections were located at the base of the bladder, the superior extremity of the rectum on the

right side, and on the left side between these points at the usual place. In six cases there were duplications of the lining of the intestine opposite the base of the bladder, on the left side of the rectum above, and on the right side of the upper extremity of that organ, and these duplications were connected together by narrower and thinner, yet equally well-marked, folds of mucous membrane. In twenty-one cases there were neither folds nor valves.

The first anatomist in modern times to describe these structures with anything like exactness was the late Mr. John Houston, of Dublin, who, in 1830, published a paper in the fifth volume of the Dublin Hospital Reports, entitled "Observations on the Mucous Membrane of the Rectum," in which he called attention to them. In this communication Mr. Houston stated that the tube of the rectum does not form one smooth, uninterrupted passage, but on the contrary, it is made uneven in several places by valvular projections of its mucous membrane extending across its canal. Physiologically he considered the valvular projections necessary to support the weight of fecal matter, and prevent its urging towards the anus and exciting a sensation demanding its discharge; pathologically he believed they explained the resistance given to the introduction of bougies; that their arrangement indicated the necessity of employing a spiral-shaped, instead of a straight bougie; that they were often mistaken for stricture, and by leading to the passage of improperly-shaped bougies had frequently brought on the very malady intended to be removed. I can find no evidence that Mr. Houston was aware of the fact that these valvular projections are occasionally connected together by narrower and thinner duplications of the mucous membrane, thereby converting these folds into a spiral membrane circling round the inner wall of the rectum.

The late Dr. George Bushe, of New York, whose excellent treatise on diseases of the rectum still ranks among the leading works on that subject, was led, by Mr. Houston's paper, to re-investigate the anatomy of the rectal mucous membrane. A series of careful examinations led him to declare, most unhesitatingly, that the folds to be observed in that structure were accidental; that the tissues were lax and naturally doubled up, but that the duplications thus formed were in no sense valves; and that, so far as the performance of the physiological

functions ascribed to them by Mr. Houston was concerned, that observer was in error. The same conclusion, practically, was reached by Dr. Bodenhamer, in his work on "The Physical Exploration of the Rectum." Both observers acknowledge the presence on the rectal walls of loose folds of their lining membrane, but both hold them to be accidental in origin, variable in situation, and of no physiological or pathological importance. Neither Syme, Quain, Ashton, Lee, Curling, Smith, Van Buren, Allingham, nor any other writers on diseases of the rectum, make allusion to these structures. The text books on anatomy, however—particularly Gray and Wilson—quote the researches of Mr. Houston with approval, and speak of the valves he describes as if one or more of them were constantly present. Yet I can find no record anywhere, of the fact that the lining membrane of the rectum may be thrown into a continuous spiral fold, such as was the case with the rectum I have described at length, and such as existed to a greater or less degree in five other specimens to which I have alluded.

In view of the foregoing facts, is it not reasonable to suppose that both spiral folds and independent valves exist in the human rectum as rudiments, and that, when present in that organ, they must be looked upon as illustrations of the law of reversion?

CLINICAL REMARKS ON INCARCERATION OF THE EPIGLOTTIS, AS A LITTLE-KNOWN FACTOR IN THE MECHANISM OF SUFFOCATION IN FATAL CASES OF SPASM OF THE LARYNX (LARYNGISMUS STRIDULUS) IN CHILDREN.

BY J. SOLIS COHEN, M.D.,

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The purpose of this communication is to direct attention to a mechanical factor in infantile spasm of the larynx, which was the immediate cause of death in two cases under my care, and which I am inclined to believe may have been the cause of death in other cases.

In the summer of 1867 I had under professional care a scrofulous male infant, between two and three years of age, with protracted

laryngismus stridulus; the suffocative paroxysms, as described by the mother, being unusually intense. On one occasion an intense paroxysm occurred in my presence, and as it failed to yield to cold water dashed upon the face and neck, or to ammonia held in front of the nostrils, I plunged my forefinger deep into the child's throat and felt the epiglottis so forcibly drawn down by the spasmodic action of the aryteno-epiglottic muscles that its free edge had become wedged between the posterior face of the larynx and the wall of the pharynx, occluding the larynx completely. Carrying the finger to the left side of the larynx I found it comparatively easy to free the epiglottis from its incarcerated position; and with the ensuing deep inspiration of air, the impending asphyxia was averted. The nature of the difficulty was explained to the mother, who was instructed in the manipulation necessary to overcome it. The constitutional remedies and other measures instituted in the hope of subduing the disposition to spasm were unavailing; and the child finally died, some weeks later, in a paroxysm similar to the one described.

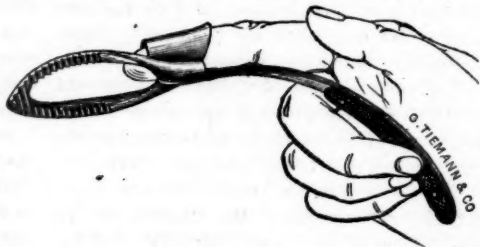
The second case occurred during the spring of 1877, in a scrofulous male infant, nineteen months of age. I had the opportunity of verifying the same sort of incarceration of the epiglottis from spasmodic action, on several occasions, one of which was in the presence of an esteemed colleague during a consultation held as to the propriety of performing tracheotomy, in view of the frequent recurrence of the paroxysms. Unfortunately it was determined to defer the decision for twenty-four hours, in order to test the efficacy of large doses of bromide of potassium; and shortly before the early hour fixed for the visit on the following morning, the child died in a paroxysm which the mother was unable to overcome by manipulation, although she had previously succeeded in elevating the epiglottis in several paroxysms.

I am inclined to believe, therefore, that the spasm of *laryngismus* affects the aryteno-epiglottic muscles, in some instances at least, as well as those muscles which close the glottis; and that the incarceration of the epiglottis, continuing after relaxation of the spasm, may be an immediate cause of death. In undoubted cases of this kind, tracheotomy may be absolutely indicated, as necessary to avert asphyxia in a recurring paroxysm of spasm.

AN IMPROVED ENUCLEATOR.

BY H. C. YARROW, M.D.,
Of Washington, D. C.

Doubtless many physicians, in endeavoring to remove small inter-cervical uterine fibroids by enucleation, have felt the desirability of having a longer index finger, and perhaps a longer and firmer nail; and as such a want has occasionally been noticed by the writer, especially with regard to a recent case seen in consultation with a medical friend, the idea suggested itself to him to devise an instrument which should, as far as possible, fulfill both indications. He is unwilling to claim any great degree of originality in its construction, as it is more or less a modification of Dr. T. Gaillard Thomas' "serrated scoop," which has been so successfully used by that distinguished gynecologist. From the accompanying wood-cut it



will be seen that the enucleator consists substantially of three parts, and the manner of fitting it to the hand and finger is well depicted. The first part is an oval, spoon-shaped fenestrated scoop, with serrations on the edge and face; the second part is a collar or band of flexible steel, with a slit in its posterior surface to fit on the finger, and a curved handle of steel partly faced with wood, which passes down the palmar surface of the forefinger, and is held in the hollow of the palm by the middle, ring and little fingers. This handle gives a support to the scoop part of the instrument, and reinforces the index finger, so that almost any degree of reasonable force may be applied; it also prevents the slit in the finger collar from opening when pressure is made, which would seriously interfere with the proper application of the instrument. When little force is to be employed, the handle may be detached from the scoop proper, as it unscrews at a point a little behind the lower border of the finger collar. In using this enucleator, it is really surprising how readily structures and growths

may be tactually appreciated, as the impulse arising from contact with them is transmitted to the pulp of the finger through the limbs of the scoop almost as well as by the direct touch. Although this instrument was originally designed for a special purpose, it may perhaps be put to other uses, as, for instance, to remove the ovum in cases of miscarriage. It may be added that Messrs. G. Tiemann & Co. manufacture and furnish this enucleator, and those constructed for the writer are beautiful specimens of the cutler's art.

VESICO-VAGINAL FISTULA AND RUPTURED PERINEUM IN THE SAME INDIVIDUAL.

BY GEORGE W. HALDEMAN, M.D.,
Of Paola, Kansas.

Mrs. Y., aged about 30 years, resident of a distant part of our county, called on me some time in January, 1876, for "repairs." Found her anæmic, nervous, dyspeptic, and complaining of some urinary difficulty; and learned, also, that this condition of her health had its origin about the time or soon after her first confinement, nine or ten years ago. The labor, it seems, was very protracted, and was finally terminated by the use of the forceps; she had a slow "getting-up," and hadn't felt "right" since. Having learned this much, and made a hasty examination, I naturally concluded that the symptoms indicated a tonic-alterative course of treatment; whereupon quinine, iron, strychnia etc., were prescribed, dismissing her with the request that she would return in the course of a month.

On or about the latter part of February following she returned, as requested, and reported herself as feeling stronger, but remarked, with considerable emphasis, that her "urinary and womb trouble" was about the same. I concluded, therefore, to make a more careful and thorough investigation, to which she assented. Placing her in the horizontal position, the existence of a ruptured perineum was readily ascertained, and to account for the constant dribbling of urine, not only the "touch," but a catheter and good light were brought into requisition, which led to the discovery of a vesico-vaginal fistula!

With this revelation of the state of affairs, I could not be mistaken as to what must be done to afford relief and perform a cure. I explained

the necessary operations in all their details, assuring her that little or no danger attended them, and that success was the rule, and failure the exception, since the discovery made by the immortal Sims. I told her also, that there were men in different portions of our country who made a speciality of operations for the cure of these and like disabilities, and suggested that she had better place herself under the care of one of these. To this she objected, but stated that she would be willing to submit to the needful treatment by me. At first I hesitated, but after a little time for consideration, consented to try it, promising to do the best I could.

Accordingly, having perfected arrangements and secured rooms for my patient in this city, the 9th of May, 1876, was fixed as the time for the operation for the cure of the *fistula*. The patient having undergone a course of preparation, ended by a thorough evacuation of the bowels, she was in fair condition for the operation, and the subsequent close confinement in bed. The operation, in the main, was done according to the plan of procedure recommended by Professor Sims, and was not attended by any difficulty worth mentioning. A Sims' catheter, with a rubber tube attached, was introduced and kept in place until after the removal of the sutures, they being removed, cleansed, and re-introduced every twelve hours, to prevent clogging. Sufficient opiates were given to splint the bowels and prevent evacuations of their contents until after the fourteenth day, when the sutures were removed, and the edges of the gap were found to be united firmly throughout.

Taking two months' time for recuperation and preparation, the operation for the closure of the perineum was done on the 8th of July. Having carefully denuded the opposing surfaces, they were brought together and held in contact by the introduction of the quilled suture, and the edges of the skin held in apposition by the use of the silver-wire suture. The former was removed on the fourth and the latter on the tenth day after the operation. The result of the operation was all that could be desired; in due time the union was complete and the cure perfect. Of course, the urine was removed at regular intervals, and the bowels kept locked the usual length of time.

In conclusion, I desire your readers to understand that I am not reporting these opera-

tions to boast of the results, or because of anything novel in the methods of procedure, but simply to place on record the fact, that there does exist at least one case of the dual character aforementioned. I say "one case;" because, when I came to examine the subject, and to prepare myself for the operation, I failed, in the writings of Thomas, Byford, Agnew, Pancoast, and Gross, to which I had access, to find a parallel case. Having some doubt as to which of the disabilities should be first relieved, I especially sought for information on this point, but failed to get it from the sources mentioned. I then addressed letters to two of these authorities, giving a statement of the quandary I was in, and asking for information, which was promptly given, but which was well calculated to render "confusion worse confounded;" one saying "operate on the perineum first, and, after a reasonable time, on the fistula;" the other recommending the "closure of the fistula first and afterwards the perineum." I chose to adopt the suggestion of the latter, because it accorded with my own preconceived ideas of what would be the better course to pursue. Certainly, the condition of the perineum in this case made the fistula more accessible, and rendered the operation for its cure less difficult.

I have another reason, which I wish to state, for reporting this, to me, interesting case, and that is that others, who like myself do not claim to be anything more than ordinary backwoods, cross-road practitioners, may become possessed of a sufficient quantity of nerve, grit, gumption, or whatever else it may be termed, to take hold of and perform many more of the delicate operations in surgery to which their attention is frequently called, whenever the opportunity is afforded, instead of sending them away from home, where they are liable to fall into the hands of an ignorant pretender or unscrupulous specialist, who is more likely to fleece and swindle than to cure his confiding victim. The benefit resulting from this course, I need hardly say, would be twofold; our patients would save money, if nothing more, and besides have the comforts of home and the care of relatives and friends; we ourselves would be stimulated "to pick our flints and keep our powder dry" for any emergency, and have satisfaction in seeing "the work of the Lord prosper in our own hands," and besides, keep a little more of the "dust" nearer home, where it would do the most

good, a *desideratum* not to be despised. Finally, I have only to mention that I was kindly and ably assisted in both these operations, by Drs. Wren, Johnson and Hoover, of this city.

THE PREVENTIVE TREATMENT OF PUERPERAL FEVER.

BY S. E. ROBINSON, M. D.,
Of West Union, Iowa.

In No. 20, Vol. xxxvii, MEDICAL AND SURGICAL REPORTER, I find a notice, under "Periscope," of "Local and Preventive Treatment of Puerperal Fever," from Dr. Fritsch. I have for some time been surprised to see little under that head in our medical periodicals. We should have had many articles from the pens of the best men in the profession, calling attention to the prophylaxis in this serious disease.

A few years since, in the discussion of a paper on puerperal fever, presented to the Iowa State Medical Society, Professor Cleaver, of Keokuk, remarked, that he could say very little as to the best methods of treatment in this disease, for the reason that he had not seen a case in his own practice for a number of years, or at least, not when his directions had been followed in the treatment of the post-partum period. I was surprised, I may say astonished, to hear that from a man of his standing and extensive practice in midwifery; for, practicing as I do, in a small town, with decidedly healthful surroundings, and doing a not remarkably large obstetric business, I was in the habit of seeing several cases annually, and I was confident that I used at least ordinary care and skill in the management of my patients.

Dr. Cleaver went on to say that he uniformly directed a copious vaginal injection of carbolized water, two, three or four times a day, for several days following delivery, and that in no case where his directions were obeyed had he seen a case of puerperal fever.

I may not have reported here just the doctor's language, but have given the substance of his remark. I do not remember just how he prepared the fluid for injection, just the quantity of carbolic acid to the pint of water (he never used less than a pint at each operation, I think), but ever since I got the idea from him, I have used it in practice, with *perfect* success, as have several of my professional neighbors and friends, and I do not doubt many others are doing the same elsewhere.

Professor Cleaver believed the disease was occasioned almost entirely by the resorption of septic matter from the decomposition of retained material in the vagina. Blood and shreds of membrane retained in the uterus would be more likely to be expelled or drain into the vagina, than they would to escape from the vagina before decomposition and leave it free and clean; consequently the thorough washing of the vaginal mucous membrane, with plenty of warm water, is the thing of greatest importance. Then, to provide against a possible want of thoroughness in the operation, it is well to add the, or a, disinfectant. My practice is to prescribe equal parts of carbolic acid and glycerine mixed (the acid is more readily and perfectly soluble in water if at first dissolved by glycerine); of this I direct a teaspoonful to each pint of warm water, or Castile soap and water, to be used as a vaginal douche, or injection, not less than a pint to be used at each operation, and to be repeated, in ordinary cases, three times a day, for the first two or three days, then twice daily for three or four days longer. I seldom find a patient who is not quite willing to follow instructions in this matter, the comfort and relief from "after pains" being sufficient inducement, even though there be no reason to fear any fever or other complications.

In cases where the labor has been tedious, or where turning, forceps, or any operation has been performed, I direct that the injection be repeated for the first three days every four or six hours, using sufficient quantity that it shall flow from the vagina free from any stain of blood, clear. Should the lochia be suppressed I still advise the copious injection; this, however, seldom occurs, though the nurse may not discover much flow, for reason of the discharge being carried away by the douche. In a few cases that had no tediousness or complication, I have directed simply Castile soap and water, and with good results.

In a few cases, the family having no convenience for using the vaginal wash, have neglected it after being advised to procure syringe, etc. I may say a Mattison, Davidson, or any syringe capable of giving a continuous stream or using a quantity of fluid without repeated introductions, and a tin wash dish, is all that is necessary, though a bed pan is quite a convenience. Then, sometimes, I am called two or three days after delivery to find my patient has

had chill, followed by fever, abdominal tenderness, arrest of the lochial discharge, and all the symptoms of the beginning of puerperal fever. My treatment then is, to insist upon the immediate use of the vaginal douche; sometimes direct a saline cathartic, and if there be any reason to suspect malarial complications, give a few doses of quinine, and if there be no malaria, the quinine does no harm; it stimulates more perfect and rapid involution, adds to the nervous force of the patient, and in that way helps to eliminate, if it does not neutralize, poison in the blood.

I can now say, with Professor Cleaver, that "I have not had a case of puerperal fever for several years." I have not used the precaution advised by Dr. Fritsch, of disinfecting the hands, but I approach my cases always, I think, with clean hands, and should not object to the use of disinfectants, brushed around and under the nails, but have not found it necessary.

HOSPITAL REPORTS.

PENNSYLVANIA HOSPITAL.

CLINIC OF PROF. DA COSTA, FEB. 23d, 1878.

STENOGRAPHICALLY REPORTED FOR THE MEDICAL AND SURGICAL REPORTER,

BY FRANK WOODBURY, M.D.

Hypodermic Injections of Iron in Anæmia.

GENTLEMEN:—The young woman now coming into the room, whom you have seen before, is a most marked case of anæmia, which we are treating by hypodermic injections of dialysed iron. Her name is Ann L.; she is 21 years of age, single and a domestic; admitted January 29th, 1878. Her father died with a chronic lung affection, and her mother was said to have had apoplexy. She told us on entering the ward that she had never been robust, although she never had any serious illness, and, in answer to our inquiries, particularly informed us that she had never had rheumatism or intermittent fever, and never was troubled with cough. Last spring her heart began to trouble her, and she suffered from palpitation and shortness of breath. About Christmas time these symptoms were aggravated and her feet began to swell; she had headache, frequent micturition, and amenorrhœa, and notwithstanding the fact that she had good food, took iron, and was well cared for, her blood became more and more impoverished.

She was before you two weeks ago to-day, in a wretched state of health, anæmic to an extreme degree; with murmurs in the vessels of the neck and in the heart; without appetite, weak

and pallid; she had not menstruated for three months. It was evident that she needed iron, but we found on several trials of the ordinary chalybeate preparations that they produced disturbance in the stomach and bowels. I then decided upon introducing iron into the system by a method adapted to insure its entrance into the blood in the most perfect and speedy manner. We commenced this treatment by throwing under the skin of the upper extremities fifteen minims of the ordinary solution of dialysed iron, but this daily dose was soon increased to thirty minims, without the slightest bad effect, local or general. The punctures have produced neither inflammation nor discoloration. In fact, she has grown so accustomed to the hypodermic needle that she makes no complaint whatever of its introduction. No disturbance of digestion has occurred, even in the slightest degree, in our patient, by this method of administration of the remedy; on the contrary her appetite has steadily improved.

A more marked evidence of real benefit, even than her improved appearance, is given by the fact that while she has been under this treatment she has menstruated during this last week, and she now wishes to leave the hospital and return home. I do not say that she is no longer anæmic, but, although she is still pale, there is evidence of a very much better condition of the blood. Another striking demonstration of her improvement is this: that the marked venous hum, which, when she was last in this room, was remarked to be so loud as to be almost heard before I placed the stethoscope over the vessels of her neck, has now nearly vanished; I do not say that it does not exist at all, but that it is much fainter and less distinct than before. She says that she feels well; her appetite is good; the bowels are regular; she has no headache; and does not suffer in the least from the secondary disturbances of the remedy. Now, since the case has reached this point of almost entire recovery, the question arises, whether to continue this treatment, or to give her the iron through the stomach, since her digestion is now so good? Under present circumstances I think it will be well to order her twenty drops of the tincture of iron three times a day. I do this, because I believe that she is almost well, and because she is going out of the hospital, and it will be necessary to give her treatment that she can carry on herself. I would not have you understand me to say that we might not have been able to obtain these beneficial results from the internal administration of iron, had her stomach always been in a condition to allow its introduction in this way. And, looking beyond the present illustration, we know that there are many cases in which we wish to give this remedy, but where it causes those secondary effects of iron on feeble digestion, with disturbance of stomach and constipation, to such a degree as to absolutely prohibit its use; cases, perhaps, of anæmia, following exhausting hemorrhages, post-partum, traumatic,

or in the hemorrhagic diathesis. In such patients the hypodermic method will yield all the advantages, without the disadvantages. Nor is it necessary to restrict ourselves to one method of administration, because in certain cases, where it is essential to have a rapid and positive influence on the blood, we can give small doses by the mouth at the same time that we give the bulk of the remedy by the skin.

Having learned by this case the practicability and advantages of this method of giving iron, we are led to consider it in especial connection with the subject of gastric ulcer, and of pernicious anæmia and pseudo-leucæmia. In mentioning the effect of iron upon these maladies, we recall the fact that hitherto it has not been very favorably noticed in this connection, chiefly, perhaps, because of the great disturbance of digestion caused by the iron, and also on account of the imperfect absorption and defective assimilation that attends these disorders. We may, however, introduce it directly into the circulation through the absorbents, by injecting this preparation under the skin, and I think with prospects of a better result than by any other method of administration.

Let me state that, for years, I have tried to use iron hypodermically, to obtain its constitutional effects in instances in which it was desirable to introduce it rapidly into the system, or in which the state of the digestion made it a remedy badly tolerated when given by the mouth. But using various salts, among them the soluble potassio-tartrate and ammonio-citrate, I found them often occasioning so much irritation that they had to be abandoned. Dialysed iron, if pure, promises well. It is, of course, essential that it should not contain acid; indeed, solution of dialysed iron for hypodermic use should be neutral in reaction. It is perfectly clear, of a deep wine or garnet color, by transmitted light, and is not astringent to the taste. The standard solution of Graham contains 24 grains of solid matter to the ounce; it is free from hydrochloric acid, and the proportion of the ferric chloride to the ferric oxide should not be greater than 1 to 27.*

[The following note was made of her condition when she left the hospital, February 28th, 1878: "The venous hum has sensibly declined; it is very faint; the throbbing of the carotids and of the jugular veins is less marked. Her color is coming back; the lips and cheeks are more natural." She had also become constipated, which was not the case while taking the hypodermics of iron.]

Exophthalmic Goitre—Its Pathology and Treatment.

The last case that I will have an opportunity of considering this morning, is that of a woman, fifty-five years of age, a widow, who, although strong-looking and of good physique, as you will see, has been out of health for several

* The solution of dialysed iron used in this experiment was manufactured by John Wyeth & Bro., which fully meets the requirements indicated.

years. I find, on consulting the records, that she was first admitted into this hospital in 1866, suffering with exophthalmic goitre, and was discharged, markedly improved, in eleven weeks. Several years after she again applied for admission, and was again relieved by treatment. In 1874 she was here for a severe cough. Two years later we find that she again entered the ward with a severe attack of acute bronchitis, when evidence of great improvement in the goitre and exophthalmos was observed. This is her fifth admission, although not always for the original complaint; I refer to them, however, for the purpose of showing you what an opportunity has been furnished here for following out this case for twelve years, and of tracing the course of this disease. The last time that she left the hospital was in 1876. She was then comparatively free from palpitation of the heart, and fullness of the neck; the prominence of the eyeballs was not marked, and her bronchitis was relieved.

When she applied for admission this time, this good record of the preceding year was not sustained by her condition in regard to the prominence of the eyes and thyroid gland. When she asked for treatment now, it was not for bronchitis, but for the goitre. The gland was again swelling, the palpitations had returned, and the eyes were again protruding.

Since the fifteenth of this month she has taken a drachm of the infusion of digitalis three times a day. Since admission she had been taking eight grains of quinine daily as a tonic. She has also had some muriate of ammonia, for a slight amount of bronchitis, which has now entirely disappeared.

I bring this case before you this morning, in order to make in your presence a careful examination into the present condition. In the first place, you observe that she has prominent eyeballs; you see a fullness in the front of the neck, but it is far from being so marked as it was, having very much decreased in the last two weeks. Now, as regards the condition of the heart. It is beating frequently, 100 times in the minute. Of course, I do not lay much stress upon this fact, as she is now under the influence of the excitement of being in your presence, but at other times I have observed this acceleration, although it is usually a little less while in the ward. The impulse of the heart is excessive, and I find upon auscultation, what has been also recorded in the notes of previous examinations, that there is some dilated hypertrophy. I said that the action was excessive, but I ought rather to say that the impulse is more extended and diffused than strong. There is an increased area of cardiac percussion dullness extending under left breast, and the apex beat is felt in two intercostal spaces, and is not in proportion with the size of the organ. There is a murmur, which is heard more distinctly at the left of the sternum, disappearing toward the apex; it is systolic in time, and not very loud. Is this a sign of valvular disease? I think not. It is, I believe, a functional mur-

mur, favored by the condition of the blood. My opinion that it is not organic is based upon this point—it is not harsh, and it is accompanied by an anæmic murmur in the carotids, not propagated from the heart nor caused by pressure from the goitre.

I bring this case before you to exhibit these interesting features. There is no question as to the diagnosis; the prominence in the neck, the protruding eyes, the heart trouble, the duration of the disease, all point to exophthalmic goitre.

One interesting question that is raised by this case, is regarding the curability of the disease. I remember seeing this patient in my previous terms of service in this hospital, and I have observed the prompt amelioration of the symptoms under treatment. Indeed, the signs have even now sensibly decreased since her admission. In reviewing the clinical history, we find evidence rather of a succession of attacks of the disease than of its steady progress. Notwithstanding the apparent hypertrophy of the heart, you will observe that I have given her digitalis, and I have seen very good effects from its use in just such cases as these. In cardiac hypertrophy, however, digitalis is contra-indicated, unless the amount of hypertrophy of the heart is not very great. In these cases I have given aconite, but think that where it is admissible digitalis gives the best results. It does do good, and I should be induced to give it unless there was a disproportionate amount of hypertrophy, and only slight dilatation.

This is largely a nervous disorder, and it is due to the direct, or rather indirect, action, through the nerves that control the heart, that this palpitation and disorder of circulation is manifested. I have found that iron, also, is of great good in these cases, and we are now giving her pyrophosphate of iron in gentian mixture; and, as she is improving, the treatment shall be continued.

Use of the Actual Caustery in Sciatica.

We learn from *The Lancet* that M. Michel Peter, of La Pitié, prefers the employment of the actual caustery to any other means of treating sciatica. A case is related in which, wet cupping having afforded but slight relief, a number of superficial cauterizations were made by an olive-headed caustery along the course of the sciatic nerve and its divisions, from the trochanteric region to the outer malleolus. About twelve of these cauterizations were made. M. Peter considers this treatment preferable to blistering, because of being enabled by it to follow the whole course of the nerve, whilst it does not produce suppuration or lead to any vesical trouble. It may also be repeated, if necessary, with impunity.

EDITORIAL DEPARTMENT.

PERISCOPE.

Dr. Gruber's New Method of Dilating the Eustachian Tube.

Dr. Gruber describes his modification of Politzer's method, in a recent issue of the *Lancet*, as follows:—

As has been already said, in order to obtain an effective separation between the upper and lower parts of the pharynx, the muscles of the soft palate must be brought into play at the same moment that the Eustachian tube is opened. All this is obtained by the simple pressure of the root of the tongue upon the hinder part of the palate, if a strong expiration is made at the same moment. If one presses the posterior part of the tongue against the palate, the cavity of the mouth is shut off from the throat, and the soft palate is pressed upward and backward. The air, which passes in expiration into the throat, has no escape either through the mouth or through the nose, of which fact one can easily convince himself by holding the hand, or a small flame, in front of the nose. The latter is not moved, and the hand is not conscious of the least breeze during the expiration, as would be the case did the air escape from the nose. The stronger the expiration at this moment, the more tense will be the soft palate, by the pressure of the escaping air, and the more effective the closure of the upper pharynx. This moment, as regards the arrangement of the pharyngeal parts, is the most favorable for giving the maximum degree of pressure to the pent-up air, by emptying the Politzer ball into the nose by the nozzle introduced as usual.

Had we always quite docile patients before us, we should certainly make use of this method; as this is not the case, we must be content with such movements as come nearest to that above described. The result of the investigations which I have made in my own mouth, and in those of patients, is that we obtain the result when the consonants "h," "k," "k," are sounded together in the most sudden manner. In such a mode of operation, much depends upon the patient's powers of comprehension, and it is often easier for the surgeon to direct the patient to repeat some complete syllable, as it will demand less explanation to make them use a vowel between the consonants, as "hack," "heck," "hick," "hook," "huck." Let any one utter the indicated syllables in succession, as they are written down, and he will find that the tongue is pushed further backward, and more firmly upward, the further we proceed in the succession of syllables, so that with the syllable "hack," the tongue is placed most forward, and with the syllable "huck" is

pushed back to the furthest degree, and against the parts above; and in this way the upper pharynx is narrowed, and effectually closed. The backward and upward pressure is stronger, and the closure more effectual when the combination of consonants "hek" is uttered without the vowel. We have also in the scale of words a means of measuring, a kind of gauge of, the closure of the upper pharynx, which is more useful, as will be seen. As the learned reader has already observed, the syllables are always written "ek," which I will explain by saying that the strong final sound falls upon "k." In proportion as the patient exerts himself to strengthen the sound of this final "k," so will it be possible to perfectly close the upper pharynx. Let us now try to utter one of these syllables, and we shall observe peculiar changes or effects in the ear; each time we find a motion in the tympanum, and not unfrequently a noise similar to that experienced in the Valsalva experiment; and the experimenter must thus cause the air to pass through the tube into the tympanic cavity.

The treatment which I now, supported by the facts given above, recommend for cases alluded to in the preliminary remarks is as follows:—The operator stands or sits, as is most convenient for him, in front of the patient, and the end of the nozzle of the syringe (the ball of which is held in one of the operator's hands) is passed to the depth of one-third of an inch into the nasal opening. The operator then, with the thumb and first finger of the other hand, closes the opening around the syringe nozzle most carefully, and, while the patient utters one of the prescribed syllables ("hack," "heck," "hick," "hook," "huck," "hek"), the ball is compressed, and the air flows with a clearly perceptible noise through the tubes into the tympanic cavity.

The Treatment of Acne.

Dr. Robert Levering says, in the *Lancet*:—

The foundation of all successful treatment depends on the promotion of a healthy action of the sebaceous glands, and the consequent prevention of comedones; therefore, all very soothing remedies, while they produce a temporary relief to the inflammatory symptoms, do not strike at the root of the malady. The basis of all treatment should be vigorous rubbing with soap and flannel, for friction with soap, more than anything else, prevents the formation of comedones, and consequently of the acne pimple. The following plan of treatment succeeds in a large number of cases: (1) The face should be steamed every night by holding it over a basin of hot water for a few minutes. (2) The skin should then be well

rubbed for five or ten minutes with soap and flannel, or a soft nail brush may be used with advantage when the skin will bear it; the soap should then be sponged off with warm water.

(3) When the face has been dried, a lotion, composed of half an ounce of precipitated sulphur, two drachms of glycerine, one ounce of spirits of wine, three ounces each of lime water and rose water, should be thoroughly applied and allowed to dry, and remain on all night. If the skin is greasy the addition of some ether to the lotion is an advantage. Sometimes an ointment is more effective than a lotion; in that case one drachm and a half of hypochloride of sulphur, ten grains of carbonate of potash, ten drops of oil of bitter almonds, and an ounce of lard may be used; or three drachms of sulphur ointment and five drachms of vaseline will be found to be a very useful unguent. Whatever is used should be allowed to remain on all night, and washed off in the morning with warm oatmeal and water, or weak gruel. If the skin becomes very tender under this treatment, it may be discontinued for one or two nights and then resumed. The most common cause of failure is want of perseverance or timidity on the part of the patient or doctor, for a temporary increase in the redness and irritability of the skin often prevents the continuance of the most efficacious remedies.

Treatment of Epilepsy.

In a lecture on this subject, quoted in the *London Medical Times and Gazette*, Professor Hardy, of Paris, observed that whatever remedy may be resorted to for this purpose, there is a precept which must never be lost sight of—viz.: that when once commenced the treatment must be, so to say, chronic—that is, continued for months or years. It may, indeed, be interrupted from time to time without inconvenience; but after a suspension of a fortnight, a month, or longer, it must be resumed, under the penalty of losing any advantages that have been already gained. Speaking of the belladonna treatment, conducted in the mode recommended by Trousseau, he says that he has met with two cases among those in which he employed it, in which he believes its success was quite complete. He thinks atropia should only very rarely be substituted for it, owing to the danger of poisonous accidents, resulting from irregular apportioning of the dose. Bromide of potassium, however, he observes, is almost the only medicinal substance employed at the present time; and from its use we may hope to obtain a cure when the disease is not very old, and if the paroxysms are not very frequent. He has himself met with several cases in which such cure can quite legitimately be said to have occurred. Like all the other remedies, it must be given in increasing doses (from two to three, four, six, and even eight grammes per diem), and must be continued for a long time—two or three years. This substance has, however, the inconvenience of inducing a certain amount of

intellectual paresis, and especially a slight loss of memory. It also frequently gives rise to irritation of the skin; and Professor Hardy has often been called to cases of obstinate eczema, which only disappeared on the suspension of the bromide. These eruptions are so persistent that by this character alone he has sometimes, in spite of the denial of their relatives, been able to state that children were taking the bromide for epilepsy.

Calomel as a Vermifuge.

Dr. E. F. Walker gives the following case and remarks, in the *New York Medical Journal*:

On October 12, 1877, a child, Mary H., three years old, was brought to the class with the following history: The mother has noticed for the past four weeks a leucorrhœa, which has become very profuse, and emits a very offensive odor. The girl is also fretful, and complains of pain in the bowels; she sleeps badly, and has lost her usual regular habit of daily evacuation from the bowels. She complains of soreness about the vulva, and great itching, which has caused her to scratch the parts until they are red and sore. On making an examination, I found the genitals much swollen and very sensitive. The clothing was covered with the vaginal discharge, which was mucopurulent and exceedingly offensive. Separating the labia, the mucous membrane was very much inflamed; but it was impossible to examine the vagina, owing to the child's youth. I then inquired carefully as to her habits, to learn if the vaginitis was not a result of masturbation; but the mother assured me she had been carefully watched, and that such was not the case. I therefore decided that the trouble was owing to intestinal worms, and ordered her to take two drachms of the fluid extract of spigelia and sumac on an empty stomach, and repeat it for four mornings consecutively. On the next visit it was said that two or three pin-worms had been vomited, but that the discharge was no better, and, indeed, was more profuse. I ordered, for an injection to the vagina, ten grains each of borax and chlorate of potash to an ounce of water, and gave her also a dose of santonine. Three days later no improvement had taken place, and I decided to administer ten grains of calomel in a single dose, followed by castor oil. Two days later the mother reported that the powder and oil caused the child to pass "a ball of little worms," and that the discharge was much better. Still there was considerable soreness about the parts, and I ordered the oxide of zinc to be dusted over the surface, and also to be combined with water and thrown up into the vagina.

Subsequently I saw the child, and then she complained of the discharge from the rectum, and said that it was tinged with blood. This, however, at the present writing (November 25th), is rapidly disappearing. I find that, among dispensary patients suffering from these intestinal worms, large doses of calomel seem

to give better results than any of the ordinary drugs; and I have made it almost a rule, when satisfied that the worms occupy the canal, to give one large dose of calomel. The treatment has been pretty uniformly successful.

Chronic Diarrhoea of the Aged.

In a late number of the *Gazette des Hôpitaux*, Dr. Potain states that the diarrhoea of the aged has been separately described, with its anatomical changes, such as thickening and other alterations of the mucous membrane. In such cases there is little disturbance of the digestion, and no pain in the abdomen, and that even when deep ulceration of the intestines has been found after death. The patients become pale and bloated (*bouffis*); their skin becomes thin; they waste away, and fall into a state of complete apathy—the diarrhoea much resembling, therefore, in this form, that of pellagra. There is nothing special here in the etiology, and all that can be said is, that old age constitutes an extreme predisposition to enterocolitis. In the patient under notice, no other reason than his age can be assigned; yet not his age calculated on the number of years, for these are only sixty-two, but the age he presents in his condition of anticipated senility. It has, indeed, been said long since, with reason, that we are of the age of our arteries; and this man has aged arteries, for they are atheromatous, and, moreover, he exhibits all the attributes of senility. In such cases the prognosis is always a most serious one, and, according to M. Durand-Fardel, the disease is incurable when it has lasted for some weeks. This opinion is certainly exaggerated, but it is a fact that a cure is extremely difficult, because in aged persons we can produce no action on the skin and kidneys which will balance the intestinal function. In this patient, although in his case there was no history of prior marsh-poisoning, quinine has been given with great advantage. It would seem, therefore, that besides its anti-periodic power, the sulphate of quinine, by the property which it possesses of inducing contraction of the capillaries, may diminish the vascularity of the intestines, and modify their secretions.

On "Black Small Pox."

Dr. Collie recently presented an interesting paper to the London Epidemiological Society. After giving details of two cases of hemorrhagic small-pox, one following an attack of scarlet fever, the other an attack of enteric fever, in both of which death took place suddenly and without any warning, he went on to show how closely such cases resembled the accounts of the "black death" of the middle ages, as given by Vinario and others. To his mind there was no doubt but that black small-pox and black death were identical; and he further thought that black small-pox formed the chief part of the plague of Athens, so graphically described by Thucydides. In recent

as well as in the present epidemic, there had been a large and increasing proportion of black cases, and should vaccination be neglected, Dr. Collie thought that small-pox might possibly assume its middle-age virulence. He stated that black small-pox occurs invariably in unvaccinated persons, or in persons who have not been revaccinated after fifteen. He then gave the history of a case of what appeared to be, from the eruption, mild small-pox. The patient, aged twenty-one, had two good vaccination marks. Death occurred an hour after admission. The post-mortem examination showed that the anterior part of the corpus striatum and the whole of the right hemisphere were ploughed up with blood. So far as he knew this was the first case of the kind on record. Then followed a case of confluent small-pox, with extensive hemorrhage into the vesicles, in a female aged sixty, with no evidence of vaccination, in which, contrary to expectation, recovery took place. With regard to compulsory vaccination laws, he thought that compulsory laws which are practically not compulsory were ridiculous, and that, as regards vaccination, such laws served to retard rather than to advance its progress. Dr. Collie concluded by saying that no vaccination can be held efficient which did not include revaccination about puberty, and that vaccination should be the business of the State, and be performed by specially trained State officers, private practitioners, except in exceptional circumstances, being interdicted from vaccinating.

On the Elimination of Mercury.

Dr. E. W. Hamburger, of Franzensbad, sums up a paper in the *Prager Medicin. Wochenschrift*, 1877, quoted in the *London Medical Record*, with the following conclusions:—

1. Mercury can be distinctly found in the urine of patients who have been treated with mercurial suppositories for some time. In one case, in which the treatment had been commenced four days previously, mercury was not found in the urine. Mercury is always present in the urine of patients who have been treated by inunction.

2. In patients treated with suppositories, mercury was always found in the milk as well as the urine. In cases of inunction, although mercury was present in the urine, none could be found in the milk; and, when mercurial inunction was substituted for suppositories, the mercury disappeared from the milk, although it continued to be present in the urine.

3. The feces of a patient who was treated by inunction contained a large amount of mercury. Dr. Hamburger concludes, hence, that the elimination of mercury takes place chiefly by the bile.

The chemical process used consisted in the removal of organic matters, the application of electrolysis, and the formation of iodide of mercury, the crystals of which were readily recognisable under the microscope.

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2. For two new subscribers to the REPORTER, a copy either of *Napheys' Medical Therapeutics* (\$4.00), or *Napheys' Surgical Therapeutics* (\$4.00).

3. For one new subscriber to both COMPENDIUM and REPORTER, both the *Physician's Pocket Record* and *Dobell on Coughs, Consumption and Diet*.

In all cases the remittance for the new subscriber must cover one full year's subscription.

THE CAPTURE OF THE MEDICAL OUTPOSTS BY THE LADIES.

One of the more remarkable events in the medical history of the past year has been the steady advance in medical science and practice by the fair sex. The examinations which they have passed in Paris, Switzerland, and several of the English schools, are spoken of as fully as severe as those of their male associates, and as a rule, even better withstood. The Boylston prize essay in this country was given to a woman, although the sex of the author was necessarily unknown to the critics who awarded the prize. In fact, it looks as if the male sex had better look to its laurels, or they may find themselves shelved some fine day, and recommended to stick to avocations requiring less brain power and energy than those for which nature has fitted the fairer half of the species.

Nowhere has this conquest been more apparent than on the conservative soil of our mother country. Women can now obtain a full medical education in England, and can obtain a registrable diploma in Great Britain, entitling them to practice the medical profession. Mr. Russell Gurney's Act of 1876, permitting any licensing body to admit to examination for its degrees or diplomas any persons, without regard to sex, was, early last year, accepted and acted on by the King and Queen's College of Physicians in Ireland, and several female candidates have since passed the examination of that body. The Senate of the University of London also decided to admit women to examination for its medical degrees, though difficulties have as yet prevented that decision from being carried into effect. There remained for a time the obstacle that female medical students could not anywhere in Great Britain or Ireland obtain the hospital practice required by our licensing bodies. This last remaining difficulty also has been overcome. The Royal Free Hospital has been affiliated to the London School of Medicine for Women as a clinical school for female students; and at the beginning of the present winter session its

wards were formally opened to the students of the School of Medicine for Women, with the object of providing them with the necessary hospital practice and clinical instruction. Women have thus, with great energy and perseverance, triumphed over all the difficulties that beset their determination to enter and practice the medical profession.

As we have the fullest kind of confidence that the influence of intelligent and pure women is always and everywhere for good, we contemplate with satisfaction these measures, and trust that no country will be churlish and short-sighted enough to oppose such measures.

NOTES AND COMMENTS.

Lectures to Practitioners.

The physician obliged, as most are, to practice his profession in small towns and rural districts cannot help getting "rusty" as time progresses, and very many often wish they could spare the time to attend another course of lectures. This, however, requires near half a year, a period too lengthy to be absent from practice.

To meet their requirements, a very excellent arrangement has been in progress in Berlin for two years. The professors of the University deliver a series of lectures, of four to six weeks' duration, addressed to practitioners of some years' standing, and with a special bearing on new remedies, instruments, diagnostic points and medical discoveries. As the details necessary for students are omitted, a vast amount of information is condensed in these short courses, and just in the form which the general practitioner desires.

We earnestly commend this example to the consideration of the teachers of this and other centres of medical instruction in the United States. Surely, such a course would be warmly welcomed and largely attended.

The Persian Insect Powder Flower.

A writer in the London *Chemist and Druggist* observes that several species of *Pyrethrum* are grown in parts of Europe—*P. carneum*, *roseum*, etc.—for their flowers, which are very obnoxious to insects, are sold, when powdered, under the name of Persian or Caucasian insect powder. In 1870 these flowers were

exported from Ragusa to the value of £1104. That from the Caucasus is the best. The amount of this powder consumed annually in Russia is said to be about 500 tons. A quantity of these plants grown upon 18 square rods is estimated to furnish nearly one hundredweight of powder, which is best preserved in closed vessels of glass. As generally sold, the powder is very much adulterated and worthless, often mixed with sumach. A good insect powder ought to stupefy a fly in one minute if four grains are sprinkled on it in a vial, and death should ensue in two or three minutes. Some of the commercial insect powders, however, require fifteen to thirty minutes to kill a fly.

The pyrethrum flourishes very well in the open air, in the Middle States of this country. The editor of this journal raised two beds of the *P. roseum* last summer. They flowered in August. No doubt they could be cultivated successfully for their commercial value.

The Hypodermic Use of Iron.

This important method of using iron is well illustrated in the clinic of Professor Da Costa, in the present number. Those who employ it in this manner, to be sure of satisfactory results, must see to it that the solution used is perfectly dialysed and absolutely neutral. Some preparations have been found to be acid, others to contain ammonia, etc. The strength of the iron should be not less than twenty-four grains to the ounce. That used by Dr. Da Costa was manufactured by John Wyeth & Bro., of this city, and it was of the desired strength and quality.

Treatment of Cancer by Artificial Anæmia.

The *Gazette Hebdomadaire*, of February 15th, states that Professor Bouchut has laid a proposition before the Académie des Sciences, with the following object: "By preventing the arrival of blood in cancer of the breast, we may suspend nutrition and prevent its development, so as to produce a cure. This is what is called *ischæmia*, which may be secured by permanent compression effected by means of vulcanized caoutchouc. Permanent *ischæmia* of the breast induces the gradual atrophy of this gland; and applied for the treatment of cancer or adenoma of the breast it may suspend the capillary circulation of these morbid productions, so as to lead to their atrophy. The best means of producing this *ischæmia* is the permanent application of a compressing cuirass

of vulcanized caoutchouc, lined with several thicknesses of wadding."

This suggestion is by no means new. The same object has been sought by ligating the arteries to the gland, by pressure in various forms, etc. (See John Hughes Bennett's *Work on Cancer*, quoted in Naphey's *Surgical Therapeutics*, p. 447.)

Errors in Latinity.

An esteemed correspondent writes us, calling attention to the frequent errors in Latin phrases used by physicians. The subject has been so often urged in these columns, that it seems hardly necessary to publish his criticisms at length, but his closing advice is so much to the point that we give it in full:—

"That one can be a useful medical man, without being a latinist, is not questioned; and it would seem to admit of just as little doubt that, writing to enlighten his fellows, he should confine himself to his mother tongue; we would say in all cases, but certainly, at least, when he knows no other."

The Compensation of Physicians.

A very well known and highly respected physician of this State writes us:—

Many thanks for your excellent article on "the Rate of Compensation of Physicians." This subject has often been before my mind, and I have felt that I ought to say something in the *REPORTER* about it. It has always seemed to me a most dishonorable thing, to extort from those who have confided in our honor. What would some of those extortioners say to a patient who, before entering on the treatment, should inquire what his charges for every visit would be? Instead of doing that, our patients confide in our honor; and we should be ashamed to extort from them. There is in our profession, now, an exhibition of great greed—nor is it exhibited alone in high and extortionate charges. It is seen in the refusal to go to the patient at all, until he has been reproached and humiliated and made to promise speedy payment, when, to do so would be an impossibility, in these times of no work. I have seen some accursed doings. The idea is abroad, that "the doctors are a set of grabbers." There is no nobler profession; every day pours its blessing on the head of the "true physician," blessing sweetened by the consciousness that it comes from his own labor.

CORRESPONDENCE.

Tearless Lunatics!

ED. MED. AND SURG. REPORTER:—

The experience of Dr. Kunst, of the West Virginia Insane Asylum, is not exceptional, when he says that the insane do weep. So must every man say who knows anything about the insane. And it is, to say the least, surprising that the *British Medical Journal* should give credence and space to such a blundering statement as that lunatics never weep.

I have served in two private asylums where the elite insane do congregate, and I have seen dozens of them cry and shed tears. Indeed, I cannot recollect any class of them that does not weep. Blanford says one-fifth of all the insane registered in private asylums in England are paretics. I have seen paretics weep freely. So have I seen those afflicted with what is generally called emotional insanity weep; those also with intellectual insanity; and so homicides and suicides, and those afflicted with all manner of delusions; so in the melancholic, menstrual, and epileptic. It occurred more frequently in some of these than in others; but as that is not the question, I drop it. Yet the insane weep far less than the sane would under like circumstances. Some *classes* of them weep very rarely, and some *individuals* never. An epileptic lady now in my care did not drop a single tear over the loss, by death, of her son and husband; she has not wept in twenty years. As in the sane, those who weep seem benefited by it; and who has not heard some of them wish they could weep? Yet it does not mean the same thing in the sane that it does in the insane—that is, it is not accompanied by the same amount of keen, deep feeling, nor does it produce the same relative feeling of relief.

General sensation is variably, but greatly, diminished in all lunatics; else, whence the pleasure of pricking their flesh with pins and needles? a common practice; or, of introducing a large tumbler into the rectum? as occurred recently in a Philadelphia asylum; or, of introducing over one hundred pieces of glass into the flesh of the arm, as recently occurred in a New York asylum? As is the bodily, so also is what might be called mental, feeling benumbed in the insane; they do not feel, or fully appreciate, their lost estate (how fortunate that it is so!), for while this moment they "*must go home*," next moment they are in a rollicking laugh, enjoying, in fancy, sights that it has not entered the heart of the sane man to conceive, which his "eye hath not seen, nor ear heard."

Therefore, to sum up, it is true, as this unknown writer says, that a gush of tears—or, as he says, the nearest approach to it—sometimes precedes recovery; but, *per contra*, it also occurs, as before stated, in general paralysis of the insane; and who ever saw its subjects

recover? Whether the forced suppression of deep feeling, of grief or sorrow, by voluntary effort (a question practical and apropos to the now, I trust, exploded one of tears amid lunatics), tends to a fatal result, I now submit to those with some knowledge on the subject. Scott (*Antiquary*, vol. II, chap. 7) makes one say: "Heaven only knows whether the suppression of maternal sorrow which her pride commanded might not have some effect in hastening her own death. It was at least generally supposed that the apoplectic stroke which so soon afterward terminated her existence was, as it were, the vengeance of outraged nature for the restraint to which her feelings had been subjected." T. J. HUTTON, M.D.
Brigham Hall, Canandaigua, N. Y., Feb. 27th, 1878.

Sexual Exhaustion.

ED. MED. AND SURG. REPORTER:—

THE MEDICAL AND SURGICAL REPORTER for December 22d, 1877, by chance, came to my notice, containing, among other good things, the valuable lecture of Dr. H. C. Wood, on the above subject. In this, page 482, occurs this passage: "As sleeping on the back provokes emissions (why, I do not exactly know), he must always sleep on his side," etc.

Allow me to offer an explanation, one that may or may not, have occurred to your readers, which, if it does not enable them to "exactly know"—positively, is as correct as any pathological condition undemonstrable by chemical or microscopical investigation can be known.

It is well known that emissions are provoked by lying on feathers, more than any other material. Now a person afflicted with spermatorrhœa in any form lies on his back on feathers. These being a non-conductor of heat, the warmth of the body generates an electrical stimulus in the spinal nerves leading to the upper extremity of the medulla oblongata—the seat of sexual impulse—produces the seminal aura resulting in an orgasm and consequent loss of fluids. This is almost inevitably the case. All thinking and observing physicians, I think, will agree that the organs of sexual sense are located in, or near the medulla; and they likewise know that heat will produce bodily electricity, and that the effect of this stimulus would be the seminal aura stated. Sleeping on the side, of course, prevents this. So, sleeping on hard, cooling beds likewise destroys this tendency. In cases of extreme sensibility, lying on the face will produce emissions, by irritation of the glans, if erection is caused by distended bladder or other cause. Lascivious dreams are the more frequent accompaniment of the latter.

Spermatorrhœa is, as Dr. Wood remarks, rare in its severest form. Yet there is great need of caution to the young, for the practice of masturbation, whenever carried beyond moderate limits, is productive of serious injury. There is much that does not come to the knowledge of the physician till health is greatly impaired,

from the reluctance to seek counsel and advice till necessity compels. And yet, I doubt not but that, in the far greater number of instances, more injury is done by marital excess than self-gratification, unless the habit be acquired before puberty, or unusually frequently indulged in. Sleeping on hard beds, with no more clothing than absolutely required, with plenty of exercise and avoidance of all excitement of the sexual organs, is generally sufficient for milder forms. Confirmed cases require immediate and judicious treatment. I. HERBERT NEWTON, M.D.

Leicester, Vt.

Phonation in Tracheotomized Subjects, Without Occlusion of the Tracheotomy Tube.

ED. MED. AND SURG. REPORTER:—

In the REPORTER of this date there is reported a clinic held by me last winter, in Jefferson Medical College, in which I exhibited a tracheotomized patient who could speak loudly without occluding his tracheotomy tube.

Curiously enough, a second case has occurred under my care, in a man upon whom Dr. S. W. Gross performed (in the hospital) a temporary tracheotomy, on account of tumors in the larynx; and from whom, after destruction of the most superficial growths through the mouth, I finally removed a pedunculated polyp through the tracheotomy wound, leaving the parts clear above and below the glottis. On the 6th instant, during a surgical clinic held by Dr. John H. Brinton, being about to remove the tube permanently, the patient was exhibited to the class for the purpose of letting them see daily the process of unaided nature in closing a tracheotomy wound; and before removing the tube I took the opportunity of demonstrating that this man, too, could speak loudly enough to be heard all over the lecture room, without occluding his tube. J. SOLIS COHEN, M.D.

1431 Walnut St., Phila., March 9th, 1878.

Sulphas Americane Australis.

ED. MED. AND SURG. REPORTER:—

In the March number of the *American Journal of Pharmacy*, under the heading of a "Curious Synonym for Quinia," the following remarks are made:—

"Recently we were shown a prescription in which the first article ordered was—

"R. Sulphatis Americane Australis, gr. xxiv.

"This South American sulphate was interpreted to mean quinia sulphate, the former term having been probably selected by the physician because, from a fancied idiosyncrasy or dreaded ill-effects, the patient was imagined to be unable or refused to take quinia;" and, as the writer of the present article happens to be the physician referred to, he rises to explain:—

Beginning practice in 1862, in one of the most malarious districts of the Middle States, I experimented largely, for years, with most of the known antiperiodics. After a faithful ex-

perience, I always have, and now do, unhesitatingly select quinia as the best of them all, whether considered therapeutically or economically. From my earliest professional days, however, I have (as doubtless most practitioners likewise), encountered a deep, constantly met with, and causeless prejudice to the use of the preparation of Peruvian bark in question. With the view, then, of nullifying, as far as possible, the annoyance resulting from such prejudice, I early adopted, as a synonym for quinia, the caption of this article, "Sulphas Americanæ Australis," and by having it understood by the druggists of my neighborhood, have not only succeeded in puzzling such of my patients as insist on reading my prescriptions, but have also secured to them the beneficent results accruing from the taking of this most valuable "South American sulphate."

Whether the general adoption of some such synonym is expedient or necessary at present, is respectfully submitted. Of one fact, however, the writer is certain; it has done good service in many cases, for him.

I. GILBERT YOUNG, M. D.,
1000 Shackamaxon St., Philadelphia.

Chronic Splenitis Successfully Treated with the Polymnia Uvedalia.

ED. MED. AND SURG. REPORTER:—

The success attending the treatment of malarial diseases, especially where the spleen is involved, sometimes exceeds the comprehension of some of the most learned in the medical profession. A case recently treated with the Bearsfoot, I thought would prove interesting to the readers of the REPORTER. Some three weeks ago I was consulted by Newton M., aged twenty-five, who complained of pain in the region and over the seat of the spleen, and upon examination, I found tenderness, with marked enlargement of the organ. Upon questioning him, he gave a history of a series of attacks of intermittent fever about a year previous to consulting me. Thinking this would be a good case to test the merits of the Bearsfoot, I accordingly prepared an ointment, after the following formula—

R. Fl. ext. polymnia uvedalia, ℥ij
Adeps, 3j. M.

and directed that it should be applied twice daily. I also gave, as an internal medicine—

R. Wine of pepsin, ℥ijj
Mur. acid, 3ss
Syr. simp., 3j. M.

Sig.—Teaspoonful after meals.

One week later my patient returned, saying that his side was much better, and that the pain had changed. He, moreover, complained of headache, for which I gave small doses of morph. sulph., and advised the continued use of the uvedalia ung., as I was anxious to know something of the result of the vaunted cures by the uvedalia, and in less than a week he again

returned, saying that the pain and soreness had entirely disappeared. It has now been over a week since he has felt anything of the pain. From the limited experience I have had with polymnia uvedalia in the form of an ointment for chronic rheumatism, it has given very good satisfaction. It relieves the pain incident to that disease, and gives better use to the joints than any application in the form of an ointment that I have used.

J. Q. A. CLOWES, M.D.

Shiloh, Ohio, March 4th, 1878.

NEWS AND MISCELLANY.

Pension Office Business.

An official report to Congress states that at the beginning of the present month the number of calls for proofs on pending cases in the Surgeon General's Office amounted to 18,500. At the end of the last fiscal year the reported cases for that year amounted to 14,700. The number of cases in arrears in the Pension Office amounts to 60,000, in addition to the 18,500 already called. In the Surgeon General's Office there are 16,000 folio volumes of hospital records. Only about 500,000 cases have been indexed, and it is estimated that but one-fifth of the work required is completed. It will require twenty-five clerks for two years to complete the indexing.

Increase of Myopia.

The English journal, *Nature*, says—"The alarming rapidity with which short-sightedness is increasing among German students formed the subject of a recent debate in the Prussian Parliament. From extended observations made in the gymnasia, it appears that the number of the short-sighted increases from 23 per cent. in the first year to 75 per cent. in the ninth or last year. The too frequent custom in Germany, of forcing the lads to study during the evenings, with insufficient light, in ill-ventilated rooms, is undoubtedly a main cause of this widespread evil."

Progress of Cremation.

Mr. W. Eassie, of London, in a recent lecture, informed his audience that during last year sixteen cremations had taken place in the Milan district alone, with the full sanction of the Italian Government, and they were attended by the municipal and sanitary authorities. In France, Holland, Austria, and Russia, and in some parts of Germany, Government sanction had been applied for, and only some formalities were delaying the necessary authority. Switzerland had already legalized it, and, in proof of the antiquity of the custom, Mr. Eassie stated that the rite of cremation was still practiced by the aboriginal Indians. More singular still, it appears that about the year 1844 the sanction

of the authorities of the City of London was obtained for the cremation, within the City of London gasworks, of the dead of Bridewell Hospital; an arrangement was also concluded with the City authorities for the cremation of bodies of dead prisoners, and of the condemned meat and offal of the markets. The project, however, met with so much opposition from certain churchmen that it fell into abeyance.

Longevity of Quakers.

According to an official statement, the number of deaths among the Quakers in Great Britain and Ireland during the last year was 308—125 males and 183 females. There are 14,500 Quakers in Great Britain, and 3000 in Ireland. The mortality, consequently, bears a very favorable contrast to that of the population generally. There were only nineteen deaths of children under one year, and but forty-nine under twenty years of age. It may here be remarked that the regulations of the Society respecting the registering of children provide that none shall be considered as members unless both parents are in membership at the time of birth. This is frequently not the case, and a large number of children of Quakers are thus not included in the statistical tables. To this fact may partly be attributed the general idea of the small number of births in the community. Many of these children are received into membership as they grow up, but others, of course, die, and the number of deaths of children thus seems below what it really is. Out of the total 308 deaths, the largest number in any one decade of life was in that which included those aged between seventy and eighty, and the next (fifty-five) those who died between eighty and ninety years of age. Eight died aged between ninety and one hundred. The average life of Quakers in the last year was, therefore, over fifty-eight years.

A Delicate Medical Question.

A letter from Paris recites this event: A young widow, whose aged husband had died, becomingly appeared two months afterward at the Paris Mairie, to announce her forthcoming marriage to her cousin. "Pardon me, madam," observed the clerk, "but the law peremptorily forbids a woman to marry within ten months of her husband's death." "Yes, truly," replied she; "but are not those eight months of paralysis to be taken into consideration?"

—It is a curious fact that by the English law every dog is allowed his "first bite," or, in other words, that to sustain an action against the owner of a dog for having been bitten by it, it is necessary to prove that the dog is a habitual biter, and that he has bitten a person previous to the one bringing the action.

—Five leading physicians in Montreal have died within a few months past.

Items.

—An application has been recently made to the Lord Mayor of London, by a Paris Society founded for promoting the use of horseflesh as an article of food, for authority to open in London an establishment for the preparation and sale of this meat. They point out that horseflesh will be an important addition to our food resources, especially to those of the poor, whose means will not allow them to entertain senseless prejudices against the new item of food; and they state that horses past working are sold at higher prices to the butchers than to slaughterers, and that the animals are treated with the greatest care, it being to the butcher's interest to have them well nourished.

—We find the following passage in the speech of an Elko (Nevada) lawyer to a jury:—"Here we have a physician, a man who, from his high and noble calling, should be regarded as one who would scorn to stain his soul with perjury. But what did he testify, gentlemen? I put the question to him plainly, 'Where was this man stabbed?' And what was his reply? Unblushingly he replied that the man was stabbed about an inch to the left of the median line, and yet we have proved, by three unimpeachable witnesses, that he was stabbed just below the Young America hoisting works."

—According to Dr. Bertherand, there are one hundred and sixty-six centenarians in Algeria, thus proportioned: eighty-eight individuals 100 years old, one of 101, seven of 102, nine of 103, fifteen of 104, six of 105, six of 106, five of 107, one of 108, three of 109, eight of 110, two of 111, two of 112, one of 113, two of 114, four of 115, one of 117, and one of 118 years.

—The general introductory lecture at the opening of the auxiliary department of medicine of the University of Pennsylvania was delivered March 11th, by Dr. J. G. Richardson. His subject was "Medical Skepticism and Medical Superstition."

—Dr. Cornelius Boyle, of Washington, died March 11, aged sixty-one years. He was a native of that city, and resided there all his life, with the exception of the time he was in the Confederate service.

QUERIES AND REPLIES.

MR. EDITOR:—I have a very serious case of dysmenorrhœa, followed by suppression for the last two months. Is there any new and improved treatment your readers can suggest a trial of. It is a young lady. LONG ISLAND.

DEATHS.

FLETCHER.—After a protracted illness of six months, at his residence, in Chambersburg, O. D. R. Fletcher, M.D., aged 46 years.

ROBERTS.—In New Hope, on March 7, 1878, Mary S., wife of Judson Roberts, and youngest daughter of the late Charles Fronefeld, of Philadelphia.

SHAFFER.—On the 11th instant, in this city, Martha Fotts, wife of Charles Shaffer, M.D.